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ABSTRACT

A variety of psychotherapeutic techniques have been used to treat anorexia nervosa with varying degrees of success. Group therapy has advantages to offer anorectic patients in the form of certain curative factors including consensual validation from other anorectic group members, models of coping, peer feedback, and active participation in the treatment process. The effectiveness of group therapy, begun two years ago with a small, selected sample (N=14) of anorectic patients as an adjunct to their individual treatment, was investigated. Results indicated that six are still in treatment, one was discharged as cured, five dropped out after relatively short periods in the group, one left the group in order to focus on family therapy, and one patient died accidentally. The six continuing patients differed from the dropouts in that they tended to be older and more separated from their parental homes. They seemed committed to their groups and showed themselves to be capable of functioning in group therapy and benefiting from it. However, despite this success, there are potential problems with this technique of which therapists should be aware, such as continued identification as an anorectic and teaching of anorectic behaviors to each other by group members. (Author)

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Group Therapy for Anorexia Nervosa[1]

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Anorexia nervosa is a maturational disorder characterized by severe weight loss and refusal to eat, or compulsive overeating followed by vomiting, compulsive exercise, or fasting. Until recently it was considered to be relatively rare. Over the past decade, however, anorexia nervosa appears to have become increasingly common, with current prevalence estimates ranging from about 1 in 250 to 1 in 100 adolescent girls (Crisp, Palmer & Kalucy, 1976) (only about 1 in 15 anoresic patients are male).

Many of the symptoms of anoresia nervosa are symptoms of starvation (e.g. Bemis, 1978; Casper & Davis, 1977) so treatment is often aimed at normalizing the patient's weight before meaningful therapy is attempted (e.g. Bruch, 1978; Dally, 1969; Russell, 1973). Many treatments focus largely on this weight restoration, assuming that the problem is merely an eating disorder in which remission is achieved if normal weight is regained. Such recommended management plans as high calorie supplements, bed rest, chloropromazine and operant conditioning regimes are all directed to the acute starvation syndrome (Van Buskirk, 1977). However, it has been documented repeatedly that 25-50% of anorectic patients so treated have recurrences, severely restricted interpersonal relationships, episodes of depression, and other sequelae (Bruch, 1974; Garfinkel, Garner & Moldofsky, 1977).

Traditional psychotherapies have long been used to attempt to correct the underlying psychopathology in anorexia nervosa patients. Again, the results of these reflect the severe difficulties these patients experience. For example, Thomae (1963) described 30 anorectic patients seen at his unit, only 19 of whom would accept psychoanalysis. He used Freudian interpretation to reach these patients and found relatively good results with this kind of treatment at a 3-year follow-up. One patient died shortly after admission to the hospital,

but of the remaining 29, 10 recovered, 4 had slight symptoms and 9 had more serious ones, while 6 cases showed no improvement. Of the 19 cases treated psychodynamically, 8 improved or recovered, the lesser improvement in 9 others was regarded as spontaneous, and only 2 were unimproved. Crisp (1965) reported on 21 patients treated with a hospital routine of once-a-week individual psychotherapy plus bed rest, diet, and chlorpromazine. At follow-up a mean of one and a half years later, 2 patients had died, but 15 were at normal weight (though only 11 were eating normally). Bruch (1973) provided follow-up data on 40 of her patients, treated with a psychodynamically oriented relationship therapy, with a strong emphasis on the development of trust. While 8% had died, 60% were at normal weight and considered improved or recovered in one of the longest follow-ups in the literature (up to 14 years). Dally (1969) treated 140 patients with a combination of feeling and problem-oriented insight therapy and behavior therapy to help control weight, finding this "combination" to be more effective than non-directive psychotherapy, "classic psychoanalysis", or behavior therapy alone.

Similarly, Lucas, Duncan, and Piens (1976) described a combined medical-psychiatric approach aimed at correcting both inanition and psychological conflicts as being superior to tube feeding, behavior therapy, or psychotherapy alone. Their therapy had 4 facets: separation from the home and its conflicts; treatment of the malnutrition; individual psychotherapy initially supportive, then aimed at dealing with such issues as anger, control, ambivalence and dependence vs. independence; and family therapy for those patients who would be returning to a family setting. They reported that the majority of these patients maintained substantial weight gains and had improved in general adjustment up to 3 years after treatment.

Recently, family therapy has been applied as the primary (rather than adjunctive) treatment for anorexia nervosa, especially at the Philadelphia Clinic (Leibman, Minuchin & Baker, 1974a & b; Minuchin, Liebman, Rosman, Baker & Todd, 1973 & 1975; Minuchin, Rosman & Baker, 1978; Rosman, Minuchin, Liebman & Baker, 1976). This group has reported unusually high success rates. Using family therapy plus behavioral techniques for weight gain, they found that 43 of 50 patients (and families) were treated successfully according to a 3 month to 4 year follow-up (Minuchin, Rosman & Baker, 1978).

While by no means comprehensive, the preceding overview of current treatments for anorexia nervosa seems to indicate that combined treatment strategies aimed both at weight gain and psychological issues (during and after hospitalization) lead to the best outcomes, when both weight and adjustment are the criteria of success. Despite the variety of therapeutic techniques described in the literature, however, many patients still do not respond well to treatment.

Advantages of Group Psychotherapy

Group therapy offers certain curative factors not found in individual therapy sessions (or found in a somewhat different form). Yalom (1970) delineated ten of these. They include education (both by the therapist and other patients), instillation of hope (seeing improvement or coping in others), consensual validation (demonstration that the patient is not unique, that others have the same problems), altruism (patients help each other and feel needed), corrective recapitulation of the primary family group, development of socializing techniques (through accurate interpersonal feedback from other members, role playing, etc.), imitative behavior (of the therapist and important group members, interpersonal learning (recognition of social needs, corrective emotional experience, use of the group as a social microcosm), group cohesiveness (mutual support, social contact, acceptance, etc.), and catharsis (expressing)

strong feelings to other members or the therapist). Kaul and Bednar (1978) redefined some of these 10 factors as four sources of learning unique to group therapy. They reiterated the importance of the opportunity offered by groups to participate in a social microcosm (which may or may not represent a recapitulation of the primary family group). Kaul and Bednar continued with the second characteristic of group therapy, which they call interpersonal feedback. Obviously individual therapy provides feedback, but of a different kind from that given and received in a therapy group, where there are several people responding and to respond to. A third source of learning in group therapy, they pointed out, is consensual validation, or what Yalom calls universality. Learning that others have had the same feelings, doubts, insecurities, and problems is not only comforting and therapeutic, but fosters mutual support, trust and interpersonal intimacy. Finally, Kaul and Bednar asserted that the reciprocal function of group members as helpers and helpees may be beneficial. Self-esteem may be enhanced through the satisfaction of being a contributor to the therapeutic process (for oneself or someone else), and the patient may be more likely to attribute therapeutic gains at least in part to his or her own efforts.

Anorexia nervosa, a disorder characterized by feelings of uniqueness, low self-esteem, and misconceptions about nutrition, sexuality, adulthood, and much more, seems ideally suited to benefit from group treatment. Current treatments for anorexia nervosa often do not provide models of coping, consensual validation, peer feedback, or the increased self esteem patients get from a more active participation in treatment. The lack of assertiveness, poor body image and perceived lack of control (over self and/or the environment) characterizing anorectic patients also tend to be difficult to address in individual therapy. Group therapy would therefore seem to be a treatment of choice for

treating anorexia nervosa, since many of these issues are well-suited for group intervention. This is especially true for patients who are not candidates for family therapy either because they are already separated from their families, or because the family is uncooperative or unsuitable for such therapy, which may not provide the opportunity to explore the full complexity of issues and feelings that contribute to the problem. On the other hand, group therapy may have been overlooked for these patients up until now because of their narcissism, manipulativeness, and obsessive self-concern, which might raise doubts about their capacity to participate in group therapy. Crisp (Note 1) informally reported poor results in an attempt at group therapy on his anorexia unit. He expressed a lack of confidence in the ability of anorectics to care enough about other patients to function as group members. Since there are no actual reports in the literature of attempts at group therapy with anorectic patients, it appears that most therapists have been deterred from even trying by the negative attributes of these patients. However, group therapy seems so well suited to the special needs of anorectic patients that it was decided to at least attempt it, if only adjunctively. Such an attempt would test the unique advantages of the therapy against the equally unique difficulties posed by this particular patient population.

Accordingly, we decided initially to explore the effectiveness of group therapy with just a small sample of anorectic patients from the Psychosomatic Medicine Unit (PMU) of the Clarke Institute of Psychiatry.

The Formation of the Anorexia Nervosa Groups

The first group was begun one year ago with three in-patients, the author (as group leader), and another Ph.D. psychologist as co-therapist. After the first two trial months, the group was expanded to four patients (who could be in-patients or out-patients). Eight months later, due to increased demand, a second group was begun by the author (as sole therapist), primarily for out-patients. Each group meets for one and a half hours once a week. Both groups

are limited to a maximum of 4 patients each, so that patients do not feel compelled to vie for group time. Patients are offered the option of group therapy as part of their treatment package (which must include individual psychotherapy) only after their weight is high enough so that they are not suffering from malnutrition and their thinking is not impaired; thus, weight gain is not the group's function, although feelings about weight may be discussed.

The Patients

Patients expressing an interest in group therapy are interviewed by the author to ensure that they understand what group therapy involves, are willing to both talk and listen to others, and are sufficiently verbal to do so. Patients who are excessively competitive or regressed, or who have a strong (positive or negative) relationship with a current group member are excluded, as are patients whose age is markedly discrepant from the rest of the group.

Over the past year, 14 patients have participated in the anorexic groups, 6 of whom are still doing so. Eleven of these patients began group treatment as in-patients on the PMU, continuing as out-patients (and former in-patients) of the PMU, and the other three were out-patients referred by other psychiatrists in the area who had heard about the group. The ages of the patients range from 16 to 34, with a mean of about 23 years.

Purposes and Foci of Group Therapy for Anorexia Nervosa.

The main purpose of these groups is to provide the patients with a place to talk about feelings connected with their disorder where they can feel accepted and understood. Group sessions tend to focus on sharing their experience (present and past). This usually results in feedback from the other patients that they too have done or felt similarly. Patients report that learning that they are not alone, and are not "freaks", is comforting.

Because they feel that the others in the group understand them, patients seem to be able to discuss painful thoughts, feelings, and memories that they may not yet have been able to mention in their other therapies. This is one reason that communication between the different therapists treating the patient is important. The group also provides models for improvement, correction of misinformation about nutrition and other issues, encouragement for those who are doing well, and confrontation from an acceptable source, a peer, when issues are being avoided. Finally, the group sessions are used to help the patients to explore their feelings about relationships, love, sex, food, eating, starving, being fat and being thin--central issues for anorexic patients. The fact that the other members of the group are also anorexic seems to facilitate acceptance of the feedback, encouragement, and criticism to some degree. Limiting the membership of the groups specifially to patients with this one disorder appears to facilitate the development of cohesiveness and consensual validation. Many patients have commented on the feeling of at last being with a group of people who understand them, and the feeling of relief at not having to explain themselves. In short, the advantages of group therapy in general do seem to be operating in our groups for patients with anorexia nervosa.

Therapeutic Outcomes (thus far)

Of the 1[illegible] patients who have attended an anorexia group, 7 left group treatment. One patient died tragically in an accident at a time when she was showing much improvement (even holding a job, for the first time in several years). One of the patients who left therapy, the only male patient in the sample, was discharged from the group and from individual therapy as cured one month after his release from the hospital, after three months in group therapy (this patient was doing very well when he joined the group). Nine months later he is maintaining his improvement and has entered a vocational training program.

Five of the other 6 patients who left group therapy all did so after relatively short periods in therapy (4 to 12 weeks) and were among the youngest females. Two left group therapy after 7-12 weeks due to scheduling conflicts, upon returning to school, but continue in individual therapy. Another dropout returned home to a different city, leaving the hospital against medical advice; she committed suicide 4 weeks later. A fourth dropout left after only 4 weeks upon realizing she was unable to talk in front of other people. She is also continuing in outpatient individual therapy. The fifth dropout discontinued all therapy (after 3 months in the hospital and 2 back home) against medical advice, and seems to be slowly losing weight 3 months later. Finally, the seventh patient left group therapy after 6 months in order to focus on family therapy (since her family were beginning to be able to acknowledge their involvement in her disorder).

The six remaining patients tend to be older than the dropouts and are all living away from their parents' homes. These patients seem committed to their group and claim to trust and rely on it. Five of the six are considered by their psychiatrists to be noticeably improved, and all show improved insight into at least some aspects of their problems. Two are working full time for the first time in 2 years or more, one works part time, and one is returning to school. Of four bulemic patients, three appear to be integrating their insights with their behavior, recognizing the emotional source of an urge to binge and sometimes even avoiding the binge, a degree of control not previously possible for any of them. Two have virtually stopped binging. At the present time it is impossible to determine if these gains are a result of group therapy, individual therapy, a combination of these, or merely the passage of time, although the last possibility is not likely since these patients have been anorectic for 4 years or longer. At any rate, these clinical improvements in patients remaining in group therapy at least suggest that group therapy may be beneficial.

Furthermore, these patients can function in group therapy and truly operate as a group (i.e., they are cohesive, supportive of each other, concerned about each other and strongly committed to their group, making sacrifices and asserting themselves with authority figures in order to attend). The very continuation of the groups and the demand for a second group attest to this. In and of itself the groups' continuation may represent an advance, indicating either that the interpersonal deficits of these patients are not as great as might have been suspected, or that they can be overcome in this kind of setting. Thus, group therapy is a viable treatment for anorectic patients, many of whom are able to operate as effective group members and utilize their insights to some degree.

Considering that the sample of anorectics treated so successfully with family therapy by Minuchin et al. (1978) consisted entirely of patients aged 9 to 21, all of whom were still in their nuclear families, our results offer an interesting contrast. The patients we saw in group treatment comparable to Minuchin et al's tended not to stay in treatment--the patients who left group therapy for whatever reason were all 21 years or younger and five of them left the hospital to return to their parental homes. The one 19 year old who has remained in the group is living away from her parents, as are the four older patients still in group therapy. (One 22 year old patient is still hospitalized and may live at home when she is released). This suggests that family therapy may be the preferred adjunctive treatment for younger patients still enmeshed and living with their parents, while group treatment is more suitable for older anorectics who have already left home (at least physically).

A word of caution should be mentioned, however, about possible negative side effects of anorexia nervosa groups. We have been especially careful to avoid several potential problems. The teaching of symptoms by patients to each other (e.g., methods of vomiting, laxative and diuretic abuse, etc.) is not

allowed during group sessions, and extreme dependency of patients on each other is discouraged (friendships of group members outside the group, while not prohibited, are not suggested or encouraged). Contact with each patient's individual therapist is actively maintained to protect against the individual therapist's being split off from active participation by a patient's over-involvement in group therapy (to the exclusion of individual work). So far, these issues have been successfully countered and remain only potential hazards. Another problem is more subtle and harder to avoid; this is the potential for anorectic group therapy to increase the patient's identity as anorexic, since all her supports are directed at this aspect of her. This, too, has not yet become a problem in our groups, but it seems advisable to be aware of all these issues, with an eye to preventing them.

In conclusion, our experiences over the past year indicate that groups specifically for patients with anorexia nervosa offer a useful adjunct to a therapy program for these patients. The traditional elements of group treatment plus solidarity engendered by the homogeneity of patients (and the feeling of trust and being understood this encourages) offer the anorectics a unique opportunity to deal with their problems therapeutically, which these patients do seem able to use effectively.

Footnotes

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